

NON-PUBLIC?: N
ACCESSION #: 9507240283
LICENSEE EVENT REPORT (LER)

FACILITY NAME: Sequoyah Nuclear Plant (SQN), Unit 1 PAGE: 1 OF 4

DOCKET NUMBER: 05000327

TITLE: Reactor Trip Occurred as a Result of Lo-Lo Steam
Generator Level Caused by Personnel Error
EVENT DATE: 06/23/95 LER #: 95-008-00 REPORT DATE: 07/18/95

OTHER FACILITIES INVOLVED: DOCKET NO: 05000

OPERATING MODE: 1 POWER LEVEL: 100

THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR
SECTION:
50.73(a)(2)(iv)

LICENSEE CONTACT FOR THIS LER:
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COMPONENT FAILURE DESCRIPTION:
CAUSE: SYSTEM: COMPONENT: MANUFACTURER:
REPORTABLE NPRDS:

SUPPLEMENTAL REPORT EXPECTED: NO

ABSTRACT:

On June 23, 1995, at 0327 Eastern standard time (EST), a reactor trip occurred on Unit 1 as a result of a lo-lo level signal on steam generator No. 2. During the process of establishing a clearance for a maintenance activity on a radiation monitor, an assistant unit operator (AUO) opened the wrong breaker. The radiation monitor is supplied from the 120-volt Vital Instrument Power Board 1-II, Breaker 48. However, the AUO placed the clearance on the 120-volt instrument Power Board 1-I, Breaker 48. This resulted in a loss of power to Reactor Protection Set 1. The loss of power to the protection set caused the mainfeed pumps to go to minimum speed, as designed. The reduction in feedwater flow resulted in decreasing levels in the steam generators and subsequent reactor trip. The root cause of this event was personnel error in that the AUO opened the wrong breaker. Corrective action for this event includes the appropriate disciplinary action.

END OF ABSTRACT

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I. PLANT CONDITIONS

Unit 1 was in power operation, Mode 1, at approximately 100 percent power.

II. DESCRIPTION OF EVENT

A. Event

On June 23, 1995, at 0327 Eastern standard time (EST), a reactor trip occurred as a result of a lo-lo level signal on steam generator Ne. 2 (EIS. Code AB). During the process of establishing a clearance for a maintenance activity on a radiation monitor, an assistant unit operator (AUO) opened the wrong breaker (EIS Code BKC). The radiation monitor is supplied from 120-volt Vital Instrument Power Board 1-II (EIS Code EF), Breaker 48. However, the AUO placed the clearance on 120-volt Instrument Power Board 1-I, Breaker 48. This resulted in a loss of power to reactor Protection Set 1. The loss of power to the protection set caused the mainfeed pumps to go to minimum speed, as designed. The reduction in feedwater flow resulted in decreasing levels in the steam generators and subsequent reactor trip.

B. Inoperable Structures, Components, or Systems that Contributed to the Event

None.

C. Dates and Approximate Times of Major Occurrences

June 23, 1995 An AUO opened 120-volt Instrument Power at 0326 EST Board 1-I, Breaker 48, resulting in the loss of power to reactor Protection Set 1.

June 23, 1995 A reactor trip was initiated on lo-lo at 0327 EST levels in the steam generators because of the loss of power to the reactor protection set. The auxiliary feedwater pumps started as designed.

June 23, 1995 Operations personnel stabilized the
at 0338 EST the plant in Mode 3.

D. Other Systems or Secondary Functions Affected

None.

E. Method of Discovery

The reactor trip was annunciated on the main control room
panels.

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F. Operator Actions

The control room operators responded to the reactor trip as
prescribed by emergency procedures. They promptly
diagnosed the plant condition and took the actions
necessary to stabilize the unit in a safe condition and
maintained the unit in hot standby, Mode 3.

G. Safety System Responses.

The plant responded to the reactor trips as designed.

III. CAUSE OF EVENT

A. Immediate Cause

The immediate cause of the event was the loss of power to
the reactor protection set, resulting in a lo-lo steam
generator level initiating the reactor trip.

B. Root Cause

The root cause of this event was personnel error in that
the AUO opened the wrong breaker. This determination is
based on the AUO being fully cognizant of management
expectations for self-checking and the failure by the
employee to implement self-checking. The AUO placed a
clearance on 120-volt Instrument Power Board 1-I, Breaker
48. This resulted in a loss of power to the reactor
protection set.

C. Contributing Factors

A contributing factor to this event was that the activity was not considered to be a significant activity. As a result, the prejob briefing was inadequate. Specifically, supervisory methods were inadequate since the job performance and self-checking standards were not properly reinforced prior to the individual performing the activity. Management expectations that clearances are significant activities, regardless of the system or component, have been previously transmitted to Operations personnel.

IV. ANALYSIS OF EVENT

Plant responses during and after the unit trip were consistent with the responses described in the Final Safety Analysis Report and, accordingly, the event did not adversely affect the health and safety of plant personnel or the general public.

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V. CORRECTIVE ACTIONS

A. Immediate Corrective Actions

A standing order was issued to Operations personnel requiring concurrent verification to be performed on manipulations involving electrical components in pulling or inserting fuses, opening or closing breakers, and lifting or landing leads.

B. Corrective Action to Prevent Recurrence

The appropriate disciplinary action has been taken.

Operations management is evaluating Operations personnel to assess the implementation of management expectations relative to identified issues. These evaluations will be completed and corrective actions will be established to address the identified deficiencies, as appropriate.

VI. ADDITIONAL INFORMATION

A. Failed Components

None.

B. Previous Similar Events

A review for previous events identified six events in the last two years that resulted from Operations personnel errors. The LERs that were identified are: 50-327/93007, 50-327/94005, 50-327/94007, 50-327/94008, 50-327/94010, 50-327/94011, 50-327/95005, and 50-328/94006. The corrective actions associated with these events involved the counseling of personnel, the training of personnel, and disciplinary actions where appropriate. Additionally, Operations management previously recognized that improvements were needed in personnel performance. A series of meetings was conducted to address the previous events. These meetings informed Operations personnel of management expectations and unacceptable practices that led to the events and that individuals, supervisors, and groups would be held accountable. These corrective actions have resulted in some reduction in the number of these events. Continued reinforcement of management expectations should further reduce these types of errors.

VII. COMMITMENTS

None.

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